
Patient Placement-
Getting it Right the
First Time
UNION
HOSPITAL

Union Hospital-Who we are!

- 300 bed Acute Care Hospital
- Average Daily Census (adult &peds)-203
- ED Visit – 51,741

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Medical Necessity-Why it is so important?

- **Getting it right is the RIGHT thing to do!**
- **Increased scrutiny by all payers**
  - **Audits**
  - **Denials**
- **Financial Implications**

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What was happening at Union?

Union Hospital, Inc. is an outlier on short stays

- Medicare Pre-Payment Reviews
- Recovery Audit Contractors
- Comprehensive Error Reduction Testing (CERT) Audits
- PEPPER Data Outliers

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Action Plan

- Education on the definitions of Inpatient, Observation, Outpatient and Extended Recovery.
- Improved to assist in clarification of appropriate status.
- Documentation improvement from the Physician to Nursing Staff.
- Do a better job of telling our patient story in the medical record.
- Improved Utilization of Observation and Extended Recovery.

Determining the Appropriate level of status/placement

- Role of Emergency Department Physician
- Role of Attending/Admitting Physician
- Role of Utilization Management
- Role of Nursing

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Patient Status Options

Outpatient

- Labs, Imaging, OP Therapy
- Surgical/Interventional Procedure
  - Recovery Room Services = 6 hours of recovery any where in the hospital.

Outpatient Observation

- Allows the physician time to make a decision and then RAPIDLY move the patient to the most appropriate setting (Observation to Discharge or Observation to Inpatient)
- Billable Hours

Inpatient Admission

- Admitted to a hospital bed – Severity of signs and symptoms by the physician are documented
- DRG

Emergency Department

- Education
- Increased Utilization Management Staff
- Improved Documentation and timeliness

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Utilization Role

- Apply criteria to determine appropriate level of care
  - Criteria met for requested level
    - Proceed with placement
  - Criteria not met for requested level
    - Discuss with ER physician/PCP
    - Consider documentation
    - Obtain appropriate orders
    - Obtain second level physician review if needed

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Primary Care Physician

- Education
- Continue the ER documentation of the story
- Provide the story on direct admits
- Work with the Utilization staff for appropriate placement/status

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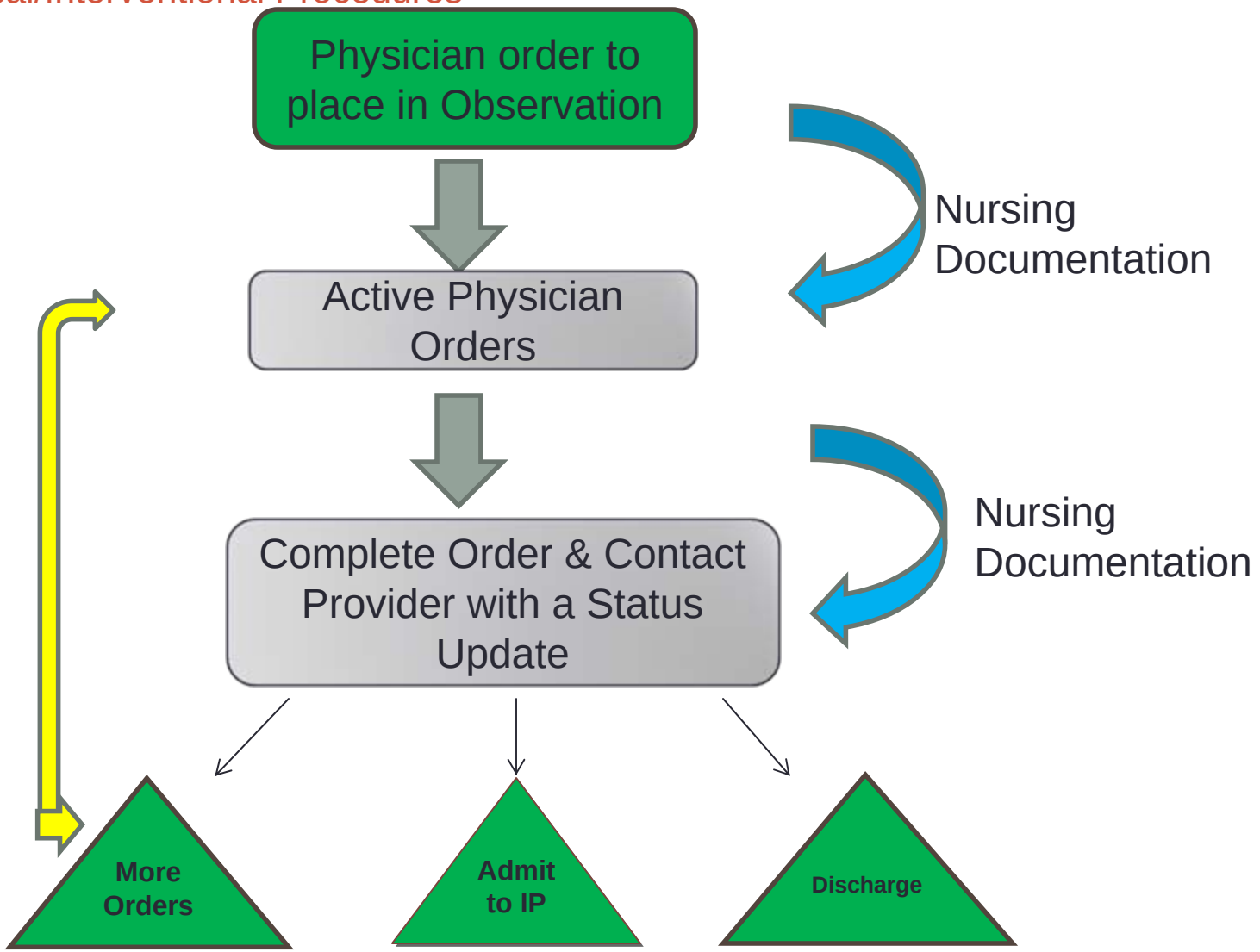
Observation Decision Tree

Exclude Surgical/Interventional Procedures



Observation Tips

- Is not a holding zone. ACTIVE treatment
  - More treatment orders – Admit to IP or Discharge Home
- OBS time must be documented in the medical record. Nursing to document the time the patient in the bed.
- Carve out for treatments or medically unnecessary time in the bed. Documentation by nursing staff is essential!
- Commonly assigned to patients with unexpectedly prolonged recovery after surgery (after 4-6 hours).

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Surgical/Interventional Procedure

- Inpatient
  - If there is a reasonable expectation that a certain surgical procedure (with high risk and potential for adverse event if done as outpatient) is going to require the patient to be admitted, rationale (the patient story) should be clearly documented in the medical record and an inpatient order given. Certain surgical procedures are required to be scheduled as “Inpatient Only”.

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Surgical/Interventional Procedure

- Outpatient
  - Should be considered when patients enter a hospital setting for minor surgical procedures that are expected to keep the patient in the hospital for 4-6 hours post procedure.

Post Outpatient Procedure

- Determine appropriate need for continued care
  - Extended Recovery
  - Observation
  - Inpatient

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Surgical/Interventional Procedure

- Standard Recovery 4-6 hours
- Extended Recovery is an option if patient is not safe to send home and needs more time to recover.
- If there is an unplanned outcome or exacerbation (an “event”) provider needs to Place in Observation status or as an Inpatient.

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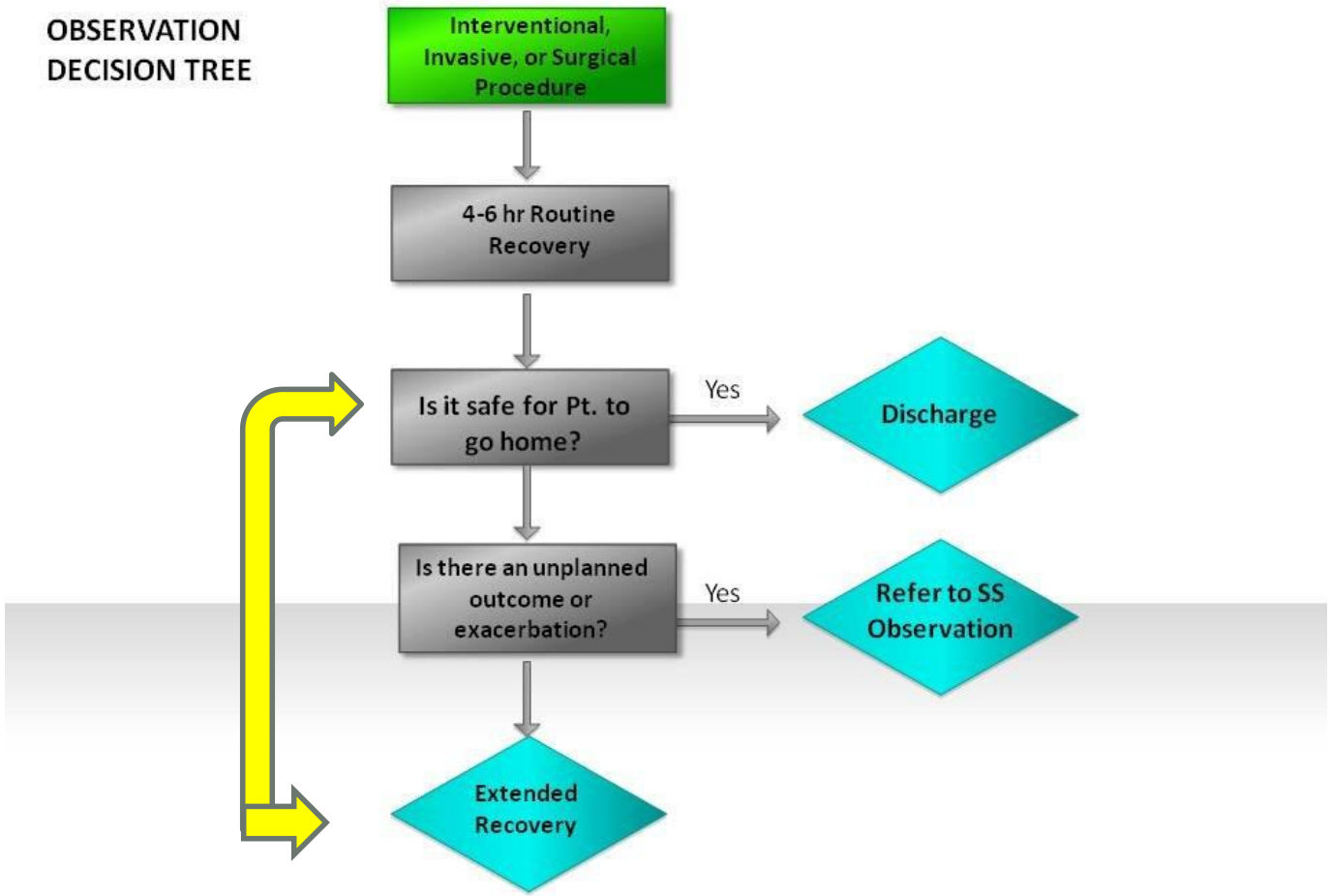
Observation Decision Tree for Interventional or Surgical Procedures



The Patient Story

Tips for Improving Documentation

Severity	Intensity	
What brought patient to hospital?	Clinical documentation tied to the severity of the condition the patient was admitted for.	Physicians & Nursing must tell the entire patient story.
Has the patient failed OP Treatment?	What is currently being done for this patient?	The entire record must reflect the need for an inpatient visit from the admit note, to progress notes to nursing's documentation
Does the pt.'s condition require admission to an acute setting?	Does this treatment require and inpatient level of care?	
Is the patient sick enough to require hospital level of care NOW?	Applies to each separate day (all care givers)	
TIE known risk factors into the reason for the inpatient admission - TODAY		

Summary Thoughts

- **Better practices in UR** –
  - Ensure UR is located in or involved in the ER
  - Bed placement only happens after UR's 'blessing'
  - Surgery and UR are joined at the hip- H&P reviewed prior to pre-payment at risk surgeries and inpt/outpt procedures.
  - Discontinue "place and chase"
  - Grow quasi-UR for after hrs and weekends
  - Engage nursing, CDI and the physicians in ongoing education on documentation to support billed services
  - Separate UR from D/C planning functions = case mgt

- Lori Horrall, RN, BSN, MSM, Manager, Utilization Management, Union Hospital

- Day Egusquiza, President, AR Systems, Inc

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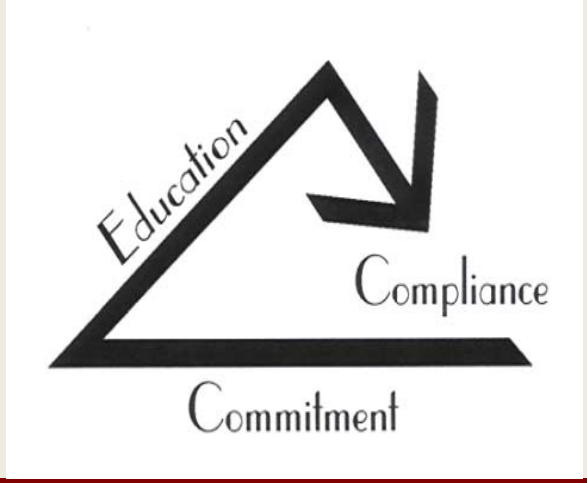
Thanks for joining us!!



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